DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

12/21/06 POC accepted Letter sent by Carson

PRINTED: 12/06/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295043	A. BUILDING _____ B. WING _____	C 11/21/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SERVICES	3101 PLUMAS RENO, NV 89509

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation conducted at your facility on 11/13/06 and finalized on 11/21/06. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following complaint was investigated: Complaint #NV00013378 alleged that the facility failed to provide the appropriate care care. The complaint substantiated. See Tag F 309.	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, it was determined that staff failed to evaluate the interventions utilized, based on the patient outcome, and then to revise the interventions as needed to facilitate the physical and psychosocial well being for 1 of 1 residents.	F 309		

D 1/10/07 Dawn HFSIV

RECEIVED
DEC 18 2006
BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Deborah Payne	Administrator	12/18/06

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 (Resident #1) Findings include: Resident #1: The resident was admitted to the facility on 10/11/06 following stays in both acute care and rehabilitation facilities. Diagnoses included Guillain-Barre Syndrome, hypertension, diabetes, and depression. She required extensive help with bed mobility, was totally dependent for transfers, and required full assist with her activities of daily living (ADLs). She had a Foley catheter in place. She received insulin coverage for her diabetes. Prior to her initial hospitalization one month previously, she resided in an independent living complex. When admitted to the facility, The Nursing Admission Evaluation, completed on 10/12/06, noted that the resident was incontinent of bowel with the last bowel movement on 10/9/06, three days prior. Admission orders from the physician, written 10/11/06 included: 1. Milk of Magnesia 30 cc by mouth every day as needed for constipation 2. Dulcolax 10 mg suppository: 1 rectally every day as needed for constipation 3. Fleets enemas: 1 rectally every day as needed for constipation if suppository or Milk of Magnesia was ineffective. Resident #1 also had an order for Surfak 240 mg as needed for constipation and Ferrous Sulfate 325 mg, three times a day with meals. A possible side effect of Ferrous Sulfate can be constipation. (The Pill Book, 12th Edition, Bantam Books) The Interdisciplinary Progress Notes documented	F 309	F 309 This facility does and will continue to evaluate the interventions utilized based on the patient outcome, and then to revise the interventions as needed to facilitate physical and psycho social well being. 1. Resident is no longer at the facility. 2. Residents with constipation will be assessed and the individual bowel protocol will be followed. If protocol ineffective M.D. will be notified of unrelieved symptoms and additional instructions received and implemented. Resident with abdominal pain or cramping will be assessed and M.D. notified and interventions implemented, response to interventions will be assessed and modified with M.D. direction.	1/4/07 1/4/07

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F 309	Continued From page 2 that the Admit Assessment, denoting the date of the last bowel movement, was completed on 10/12/06 at 10:30 AM. The as needed (PRN) Medication Record revealed that on 10/12/06 at 2:00 PM, Milk of Magnesia (MOM) 30 cc was given. There was no documentation if the MOM was effective or not. Later on 10/12/06 at 8:45 PM, the Interdisciplinary Progress Notes revealed that a Dulcolax suppository was given due to the resident's complaint of constipation. Soft stool was noted in the rectal area and the abdomen was soft with bowel sounds present. The administration of the suppository was not recorded on the PRN Medication Record. At 5:00 AM, the following morning of 10/13/06, the resident rang, concerned about the lack of a bowel movement following the suppository. It was noted that the resident's bowel sounds were hypoactive, there was soft, black stool present in the rectum and that the resident was complaining of cramping. It was also noted that the resident had a "XL BM at 003? (not legible). There was no documentation as to what the intervention was for the hypoactive bowel sounds, the soft stool present in the rectum or the complaint of cramping when the resident rang at 5:00 AM. At 3:25 PM on 10/13/06, it was noted that the resident's daughter stated that her mother was not feeling well and was told that the abdominal cramping might be the result of the laxative given the previous night. No intervention was documented other than "will follow up." At 11:00 PM on 10/13/06, it was charted that Resident #1 had two loose stools. On 10/14/06 at 5:00 AM, it was documented that the resident continued to "complain of abdominal cramping, no loose stools, didn't request pain	F 309	3. Bowel protocol reviewed and revised. L.N. staff re-educated to abdominal assessment process and documentation with particular emphasis on signs and symptoms of impaction. L.N. staff will be re-educated to PRN medication documentation including but not limited to description of effectiveness. C.N.A. staff re-educated to importance of observation, description and reporting of stools to L.N staff. 4. A.D.N.S. or designee will randomly monitor bowel protocol and PRN documentation. Results will be tracked, trended and reported to QAA on at least a quarterly basis. 5. Responsible party A.D.N.S. or designee.	1-4-07 1-4-07

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F 309	Continued From page 3 Rx." There was no evidence of an assessment being done. At 2:00 PM on 10/14/06, it was documented that Resident #1 continued to complain of abdominal cramping and loose stools. An order was obtained for Imodium, an antidiarrheal medication, which was documented as being given with "good results." The Imodium and the results were not documented on the PRN Medication Record. There was no evidence of an assessment prior to the Imodium administration. At 9:50 PM, Resident #1's daughter had expressed concern about the abdominal cramping continuing for two days. The daughter also requested that a daily Glycerin suppository be given as that was her mother's daily routine at home for constipation. The request was faxed to the physician of record. The daughter at that time also requested to speak to the facility's nurse on call (supervisory nurse), which was done. An interview was done with the facility's Assistant Director of Nurses (ADON), who during the time of the incident was on call, at 2:45 PM on 11/13/06. She stated that when she spoke to the daughter, the daughter requested that some diagnostic testing be done to determine the cause of the abdominal discomfort. The nurse told the daughter that the testing was not possible in the facility, but that her mother could be transported to the hospital which the daughter refused. Documentation for 10/15/06 read that Resident#1 told staff that she was feeling somewhat better. When the daughter arrived she told staff that her mother was continuing to have abdominal cramping and that she wanted her seen by a nurse and the doctor. The daughter was again offered transport to the hospital which staff stated that she again refused. A call was placed to the	F 309		

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F 309	Continued From page 4 physician on call who responded one hour later telling the daughter that he could not come in that day as he was in Carson City. A digital exam was performed which revealed "soft stool only." Documentation stated "will continue to monitor." At 10:35 PM, the daughter returned to the facility with a heating pad which she applied to the resident's abdomen for the cramping. Staff, at that time, gave the resident two Tylenol tablets. Documentation from the facility's on call nurse, ADON, dated 10/16/06 (no time was noted), revealed that she came in to the facility to see Resident #1. Her assessment indicated that the abdomen was soft and tender in the lower quadrant with no distention or complaints of constipation or diarrhea. She further described hyperactive bowel sounds and intermittent gas pains with relief from warm compresses. There was documentation of a digital exam. She again stated that she offered to transport the resident to the hospital and that the offer was declined by the resident's daughter. At 10:20 AM that morning, 10/16/06, a fax was sent to the physician of record about the abdominal cramping and a request to see him. It was further documented that the resident could be heard moaning and groaning from outside of her room, but that she had refused pain medication. There was no indication of any other support or intervention. An Admission History and Physical completed by the physician and dated 10/16/06, indicated that the physician was seeing the resident at the request of the daughter due to excruciating left lower abdominal pain for the last 3-4 days. Resident #1 described the pain at a 9 on a scale	F 309		

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F 309	Continued From page 5 of 1-10. The physical examination noted that the resident was pale, periodically grabbing her belly and screaming in pain with waves of discomfort. The abdomen was noted to be slightly distended with diminished bowel sounds and then runs of tinkling bowel sounds with exquisite tenderness deep in the left lower quadrant with positive rebound. There was copious black stool filling the rectal area. The impression was rule out constipation versus bowel obstruction versus diverticular disease versus other. At 12:10 PM the resident was transported to the emergency room via ambulance. The emergency room records revealed that Resident #1, when received, had severe abdominal pain upon palpation with rebound tenderness and sluggish bowel sounds. A CT scan of the abdomen, dated 10/16/06, revealed a prominent fecal impaction in the rectum with a large amount of stool throughout the colon and splenic infarct. While in the emergency room, the patient was given a Fleets enema and two doses of intravenous pain medication. The resident was then admitted to acute care on bed rest. A Heparin lock for intravenous access was inserted and oral pain medication was ordered as needed every four hours. She had a gastrointestinal consult for her constipation. She was treated with a series of enemas, Dulcolax suppository, Colace (a stool softener), Mira Lax (irritable bowel prescription), and Zelnorm (for constipation and irritable bowel) as well as Coumadin for the splenic infarct during her fifteen day acute hospital stay. Several specialty consults were done as well as abdominal x-rays, repeat CT scans and numerous lab tests. The facility staff failed to provide the necessary	F 309		

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F 309	Continued From page 6 interventions needed to obtain optimal improvement in relief of Resident #1's abdominal cramping. There was no consistent assessment of the interventions when they were provided as to any effectiveness obtained. There was no consistency in apprising the physician of the resident's status, nor any evidence that the resident's emotional needs or psychosocial condition was being addressed. Staff did not appear to be aware of her prior bowel status and of the use of a daily glycerin suppository, or that with weakness of the lower extremities caused by the Guillain-Barre Syndrome, she might lack the abdominal strength to evacuate her bowels in a usual manner. Staff did not appear to be aware that with severe cases of constipation that it is not uncommon to have liquid stools around the impaction and to remain constipated. Lastly, the assessment of the abdominal pain was not consistent or comprehensive to determine what other causes might be attributing to the pain or to alert the physician to the fact that the pain was not resolving.	F 309		